III. STATE OVERVIEW

A. Overview

STATE HEALTH AGENCY'S CURRENT PRIORITIES

/2003/ Wisconsin's State Health Plan, Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public was released in early 2002. See Appendix 1, Healthiest Wisconsin 2010 and Executive Summary. These documents can also be found at **http://dhfsweb/DPH/StateHealthPlan/index.htm**.

The state public health plan fulfills the legislative requirement to develop a state public health plan at least once every ten years as required in s. 250.07 Wisconsin Statutes. Participation in the implementation of this plan over the next decade will involve a wide diversity of partners including state and local government, not-for-profit and private sector, and consumers.

The Healthiest Wisconsin 2010 defines "public health" and the 12 essential public health services. The document describes the five system (infrastructure) priorities and the 11 health priorities that will set the stage for public health programs. The system priorities are: 1) integrated electronic data and information systems, 2) community health improvement processes and plans, 3) coordination of state and local public health system partnerships, 4) sufficient and competent workforce, and 5) equitable, adequate, and stable financing.

Wisconsin's 11 health priorities, listed alphabetically, are:

- access to primary and preventive health services;
- adequate and appropriate nutrition;
- alcohol and other substance use and addiction;
- environmental and occupational health hazards;
- existing, emerging and re-emerging communicable diseases;
- high-risk sexual behavior;
- intentional and unintentional injuries and violence;
- mental health and mental disorders;
- overweight, obesity, and lack of physical activity;
- social and economic factors that influence health; and
- tobacco use and exposure.

Underlying Healthiest Wisconsin 2010 is the comprehensive view of health that we have long embraced in Maternal and Child Health (MCH). This includes not only physical and mental health but also social, spiritual, and community well being. This view of health affirms the essence of MCH, which lies not only in the prevention and reduction of morbidity, mortality, and risk but also in the fostering of the potential for children and families to become compassionate, productive, and dignified citizens.

Starting in 2003, the Wisconsin Title V MCH/CSHCN Program will convene, once a year, a symposium to provide long-term ideas, approaches, and recommendations for implementing the MCH components of Healthiest Wisconsin 2010. The participants in each symposium will represent the widest possible diversity of stakeholders – including families, community advocates, public health, spiritual representatives, policy makers, academicians, and others.

The first symposium will address the Healthiest Wisconsin 2010 priority of mental health as it applies to the MCH population. //2003//

/2004/ Phase 2 of Wisconsin's State Health Plan is the development of the Implementation Plan. The purpose of the Implementation Plan is to identify 10-year long-term outcome objectives as related to each of the 11 health priorities and related federal Healthy People 2010 objectives. The Plan identifies actions that can be accomplished through education, social support, laws, policies, incentives, and behavioral change. The logic model serves as the basis for planning. The plan is accessible on line at **www.dhfs.state.wi.us/Health/StateHealthPlan/ImplementationPlan/**. In 2003, the Title V MCH/CSHCN Program is supporting the perinatal summit, Healthy Babies in Wisconsin: A Call to Action. See Annual Symposium in Section III. B. //2004//

/2005/ *A navigational tool was prepared to assist Wisconsin LPHDs to see the direct connection between Healthiest Wisconsin 2010 priorities and objectives, and Maternal and Child Health programs (including Children with Special Health Care Needs) as they consider making application for BC/BS resources. This is important because both of Wisconsin's medical schools require that BC/BS applications align with the state health plan's priorities. A copy of the tool is available upon request.* ***//2005//***

PRINCIPAL CHARACTERISTICS OF WISCONSIN

Population and Distribution - The state's estimated population for 1999 of 5,250,446 reflects a slight increase over the 1998 estimated level of 5,222,124. Wisconsin's population growth is expected to continue. Wisconsin has 72 counties with the greatest growth rate found in the northeastern part of the state or the Fox Valley where Oshkosh, Neenah, Menasha, Appleton, and Green Bay are located. Other growth areas include the Wisconsin River Valley, Dane County (Madison), and southeastern Wisconsin. During 1997, the largest numeric growth occurred in Waukesha and Dane counties with nearly 40,000 residents each.

Wisconsin is a predominantly rural state with 96 people per square mile. However, the population density varies greatly from county to county. For example, Milwaukee County in the southeastern part of the state has 3,950 people per square mile while Iron County, in the upper tier of northern Wisconsin has only eight people per square mile.

Females make up 51% of the state's population. The number of children under the age of 18 is 1,357,620 (1998 estimate) making up 30% of the state's population. The largest percentage of children live in the southeastern portion of the state (38%) and the smallest percent of children (9%) live in Wisconsin's northern tier.

The 1990 data indicates that 18% of children lived in single parent households. Births to single mothers have increased slightly from 25% in 1991, 27% in 1993 and 1995, and 28% in 1996 and 1997. The marriage rate per 1,000 residents has continued to decrease slightly from 7.6 in 1991 to 6.8 in 1997. The divorce rate per 1,000 residents has remained fairly static since 1993 hovering at 3.5 to 3.3 in 1997.

/2002/ Wisconsin's population continues to grow. According to the U.S. Census data collected in 2000, there are 5,363,675 people in Wisconsin. This is up from1999 estimated figure of 5,250,446 and the 1998 estimated level of 5,222,124.

/2003/ Replaced with 2004 text. //2003//

/2004/ Please note that 2003 text was replaced with this section. Wisconsin's population, according to the 2000 U.S. Census, was 5,363,675 persons, a 9.6% increase from 1990. 2000 was the first year that census respondents were allowed to identify themselves as being of more than one race and about 1.2% of Wisconsin individuals selected multiple races. Therefore, comparisons of race/ethnic groups in Wisconsin are approached cautiously. From the 2000 census, single race and ethnic categories were the following: 88.9% White, 5.7% Black, 0.9% American Indian, 1.7% Asian (Hmong and Laotian are the two largest Asian groups), 1.6% other races, 1.2% two or more races, and 3.6% of Hispanic origin, any race. In 2000, Milwaukee County had the largest percentage of African Americans at 76%, followed by Racine County (7%), and other counties in the southeastern part of the state. Also, for the first time, more than half of Milwaukee County's population was non-white. About 29% of the state's population were children, birth to 19 years; 39% of these children live in the southeastern portion of the state which includes the county and city of Milwaukee.

Since 2000, four areas show strong growth in Wisconsin: the Fox Valley (Oshkosh, Neenah, Menasha, Appleton, and Green Bay), Dane County (Madison), far western Wisconsin (adjacent to the Twin Cities of St. Paul and Minneapolis), and southeastern Wisconsin. From 2000 to 2002, Dane County gained more than 12,355 residents, followed by Waukesha County's gain of 7,310 residents. Wisconsin is a predominantly rural state with about 98 people per square mile; in comparison, Milwaukee County has 3,891 people per square mile. The 2000 census data indicate that of the total households, 66.5% are family households and 33.5% are nonfamily households. Births to single mothers has remained stable at 30% from 1999 to 2001, compared to 25% in 1991. In 2001, the marriage rate was 6.5 per 1,000 total population, consistent with the trend of decreasing marriage rates since 1980 when the rate was 8.7. The 2001 divorce rate of 3.3 per 1,000 population was a slight increase from 3.2 in 2000, but represented a general decrease in the divorce rate from 3.7 in 1997. //2004//

/2005/ *No significant changes. This information will be updated in the 2006 application as part of the required five year needs assessment.* ***//2005//***

Income and Poverty in Wisconsin - Despite record low unemployment (5.5% in 1991 to 3.7% in 1998) and continued economic growth, Wisconsin's working families lost ground last year according to the U.S. Census Bureau. Wisconsin saw a decline in household income between 1996 and 1997, according to the Census Bureau's annual report on income and poverty. Adjusted for inflation, household income in Wisconsin fell from $42,026 to $40,257, a decline of 4.5%.

Wisconsin's poverty rate for all ages showed a slight decline, falling from 8.7% in 1995-1996 to 8.5% in 1996-1997. However, children are more likely to live in poor families. Since the late 1970s, the poverty rate among Wisconsin's children (1997) has increased 50% from 10.4% to 15.1%, with those under the age of five most likely to live in impoverished families. Two counties in Wisconsin, Menominee and Milwaukee, have the highest percentage of children living in poverty--well above the state's average at 38% and 29% respectively.

/2002/ No significant changes.

/2003/ Low unemployment (3% in 1999 and 2000) and continued economic growth allowed Wisconsin's working families to gain ground according to the U.S. Census Bureau. Wisconsin saw an increase in household income between 1997 and 1999. Adjusted for inflation, the average annual household income in Wisconsin rose from $41,670 during 1997-1998 to $44,032 during 1998-1999, an increase of 5.7%.

Wisconsin's poverty rate for all ages showed a slight increase, climbing from 8.5% in 1997-1998 to 8.7% in 1998-1999. The poverty rate among Wisconsin's children (1997) has increased from 10.4% to 14.3%. Menominee and Milwaukee counties continue to have the highest percentage of children living in poverty; 33% and 28%, respectively. Other counties with child poverty rates higher than 20% included Ashland, Barron, Bayfield, Douglas, Rusk, and Sawyer. //2003//

/2004/ The following table, adapted from the Anne E. Casey Foundation, Kids Count Census Data for 2000, summarizes, by percentages, major indicators of child well-being in Wisconsin compared to the U.S.

Indicator	Wisconsin	U.S.
Population under 18 below poverty	11.2	16.1
Population under 18 below 50% of poverty	4.9	7.4
Population under 18 below 200% of poverty	29.1	37.8
Own children in single-parent households	21.7	23.3
Population, 16-19, who are not in school and not working	5.9	8.9
Children, 5-17, who have difficulty speaking English	3.3	6.6
Children, 5-15, with one or more disabilities	6.2	5.8
Children living in high-poverty neighborhoods (where ≥20% of population is below poverty	9.4	20.4

Aside from the percentage of children with one or more disabilities where Wisconsin has a slightly higher rate, Wisconsin's children are faring relatively better compared to their national peers.

The following employment data show Wisconsin's unemployment rate was lower in 2000 at 3.5% compared to 4.4% in 1990. For the years 1995, 2000, 2001, and 2002, Wisconsin's unemployment rate was consistently lower than the U.S. rate. Nonetheless, since September 11, 2001 and the economic downtown during this decade, Wisconsin's economy is stagnating and more families are at risk.

Year	Wisconsin	U.S.
1990	4.4	5.6
1995	3.7	5.6
2000	3.5	4.0
2001	4.6	4.7
2002	5.5	5.8

Many of Wisconsin's jobless population live in the inner-cities of the southeast part of the state where there are fewer opportunities for jobs that require access to reliable transportation and child care. Also, Wisconsin is dependent on seasonal workers for food processing and tourism reflecting fluctuations in employment figures. //2004//

/2005/ *No significant changes.* ***//2005//***

Wisconsin's Racial and Ethnic Composition and Health Disparity - It is expected that Wisconsin's population will continue to increase in racial and ethnic diversity to further enrich the state. The population of Wisconsin is primarily non-Hispanic White (87% in 2000). The racial and ethnic groups, African Americans, American Indians, Southeast Asians, and Hispanics report a youthful age structure with proportionately more women entering the childbearing ages.

In 2000, African Americans represented the largest racial minority group comprising about 5.7% of the total population. The Hispanic-origin population (of any race) constituted the second largest minority group in Wisconsin (3.6%). Although births to Hispanic women still constitute a small percentage (6%) of Wisconsin's total 1999 number of births, the percentage of Hispanic births has tripled in the last ten years. The American Indian population in Wisconsin includes several distinct nations: the Chippewa (Ojibwa), Oneida, Winnebago, Menominee, Stockbridge-Munsee, and the Potawatomi. The 2000 Census count was 47,228 American Indians in Wisconsin, an increase from 38,986 in 1990. The Southeast Asian population includes people of diverse national origins to include Hmong, Laotian, Vietnamese, Thai, and Cambodian has grown from 52,782 people in 1990 to 88,763 in 2000.

/2003/ In 2000, births to Hispanic women increased, although they still constitute a small percentage of Wisconsin's total number of births (6.5%). //2003//

/2004/ Although racial and ethnic minorities comprise a small percentage of Wisconsin's population (see above), it is expected that Wisconsin's population will continue to increase in racial and ethnic diversity to further enrich the state. Nonetheless, health disparities between Whites and other racial groups are prominent. Infant mortality, often used as a measure of a society's overall well-being, is significant in Wisconsin. The overall infant mortality in 2001 was 7.1 per 1,000 live births; the White rate was 5.7, a slight increase from 5.6 in 2000, but a marked decrease since 1980 when it was 9.3. The Black infant mortality rate was at its lowest for the past two decades in 1997 at 13.4. Since then it increased steadily, to 18.7 in 2001, and aside from some fluctuations to a low of 13.4 in 1997 it is essentially the same now as it was in 1980 at 18.2. There are too few infant deaths in the other racial/ethnic groups to calculate annual rates; therefore, the following three-year averages from 1999-2000 are American Indian: 10.7, Hispanic: 6.4, Asian (Laotian/Hmong): 6.1.

The following table shows disparities by leading cause of death, all Wisconsin, compared to race/ethnic groups, all ages, 1996-2000.

Leading Cause of Death All Wisconsin, Compared to Race/Ethnic Groups, All Ages, 1996-2000						
Rank	Wisconsin	Black	American Indian	Asian	Hispanic/Latino	White
1	Heart disease	Cancer	Heart disease	Cancer	Cancer	Heart disease
2	Cancer	Heart disease	Cancer	Heart disease	Heart disease	Cancer
3	Stroke	Stroke	Accidents	Accidents	Accidents	Stroke
4	Chronic lung disease	Accidents	Diabetes	Stroke	Diabetes	Chronic lung disease
5	Accidents	Diabetes	Stroke	Suicide	Stroke	Accidents

/2005/ *No significant changes.* ***//2005//***

FACTORS IMPACTING UPON THE HEALTH SERVICES DELIVERY ENVIRONMENT

In Wisconsin, programs that impact upon the health services delivery environment include BadgerCare and outreach efforts, Medicaid Health Maintenance Organizations (HMOs), Temporary Assistance for Needy Families (TANF), and Wisconsin Works (W-2). In addition, other efforts in Wisconsin that influence the health services delivery environment include: Reproductive Health and Family Planning Services, Blue Cross/Blue Shield Public Health Foundation, and Tobacco Control Settlement.

BadgerCare - Wisconsin's Title XXI, Children's Health Insurance Program (CHIP), known as BadgerCare, has continued to grow. The program enrolled 61,531 persons in its first nine months of operation, surpassed another budgeted enrollment target in 2000, and finished the calendar year at 78,063 total enrollees. BadgerCare employs a fundamentally different program design than do most CHIPs, enrolling families with dependent children who lack insurance, and whose incomes do not exceed 185% of federal poverty guidelines. The state negotiated a waiver with the CMS for its program design. Adult enrollment has continued at higher-than-expected levels, with 51,885 adults and 26,178 children at the end of calendar year 2000. In early February 2001, the legislature enacted emergency funding for BadgerCare, to ensure that enrollment would not be restricted.

/2003/ BadgerCare's enrollment growth continued in 2002, rising to a peak of 92,409 as of January 2002. In the state's 2001-2003 biennial budget, the legislature enabled further enrollment growth by providing additional funding.

However, a more accurate measure of access to health insurance for Wisconsin's low-income persons is the "family Medicaid total". This category combines both BadgerCare (CHIP) and the Medicaid enrollment of low-income families with children. This total rose by 54,887 in 2001, a 17.6% increase from a year earlier. Persons who were laid off from work may make application immediately for BadgerCare upon losing employer-provided insurance. A three-month waiting period, initially implemented to prevent "crowd-out" of private insurance, is waived in the event of involuntary job loss.

Adult enrollment compared to child enrollment continued at approximately a 2-to-1 ratio. As of January 2002, adult enrollees in BadgerCare totaled 62,155 and children totaled 30,254. The proportion of adult enrollees has been a key aspect of BadgerCare's growth. Initial program projections from 1999 forecast roughly the same numbers of children and adults. The greater proportion of adults coming into the program caused program expenditures to grow because of adults' propensity to have more costly medical problems.

Another major change to BadgerCare was the federal approval of Wisconsin's waiver request for enhanced Title XXI funding for enrolled parents. As part of the agreement, Wisconsin's BadgerCare program implemented simplified application processes, including a mail-in application. Also, the "asset test" was removed for all family Medicaid applicants. More recently, Governor McCallum announced that Medicaid and BadgerCare would be exempt from cuts in his "budget repair bill" necessitated by an estimated $1.1 billion shortfall in the state's 2001-2003 biennial budget. //2003//

/2004/ BadgerCare's growth continued through 2002 and into the first quarter of 2003 driven by word-of-mouth and demand for health insurance caused by job losses. In the state's 2001-2003 biennial budget, the Legislature enabled continued enrollment to 93,715 by providing additional funding. BadgerCare remains "open for enrollment", even though the state now struggles with a $3.2 billion budget deficit. In March 2003, BadgerCare's enrollment stood at 106,654; of that total, 71,108 are adults and 35,546 are children. However, BadgerCare's popularity has also driven "family Medicaid" in Wisconsin higher, because the state's enrollment system seamlessly categorizes family members into either BadgerCare or Medicaid. Total "family Medicaid" enrollment in 2002 increased 14.9% from December 2001 through December 2002. A measure of the BadgerCare's overall positive effect in insuring low-income children and families is that family Medicaid has doubled from July 1999 – the date of the CHIP program's inception – through January 2003. In January, the family Medicaid total was 431,261. //2004//

/2005/ *BadgerCare's enrollment growth continued in 2003, although at a more moderate pace than in earlier years of the CHIP program. In March 2003, there were 71,108 adults and 35,546 children enrolled, for a total of 106,654. By March 2004, there were 114,237 total enrollees, with 76,881 adults and 37,356 children. Enrollment increased by 7.1% in that period, significantly less than in previous years. The ratio of adults to children remained at 2-to-1. Perhaps the most important development, however, is that enrollment remains open to new applicants. In May 2004, Governor Doyle gave BadgerCare a ringing endorsement as a program supportive of his vision of "healthy kids."* ***//2005//***

Outreach Efforts - An overarching lesson in Wisconsin's early experience with CHIP is the critical importance of effective outreach. It is critical to carry out a coordinated campaign to communicate the availability of these benefits to families and help them "navigate the system." A dramatic 19% drop in the state's Medicaid rolls underscored the need for such outreach, the largest percentage drop in the nation, occurring from 1995 to 1997. The Wisconsin Title V MCH/CSHCN Program has shown its commitment to outreach in the Medicaid program in the last year, with notable results.

Several major public health outreach strategies have been implemented: the "free and reduced price lunch" initiative; the promotion of Health Professional Shortage Area (HPSA) bonuses for treating certain Medicaid recipients; and LPHD outreach activities. Thorough use of the subsidized lunch program data by school districts has

allowed continued targeted outreach in 2000. In 2000, certain health departments chose to conduct Medicaid outreach activities.

/2003/ Nine LPHDs, mainly in the state's more populous counties, were funded to conduct Medicaid and BadgerCare outreach in 2001. Federal Medicaid outreach monies from the original W-2 law allocation were used. The participating LPHDs were: Manitowoc, Outagamie, Beloit, Ozaukee, Waukesha, Eau Claire, Kenosha, LaCrosse, and Milwaukee. All of these LPHDs exceeded their initial enrollment increase targets of 5% for calendar 2001. All recorded enrollment increases ranged from 37.7% in Manitowoc to 10.7% in Milwaukee County. Moreover, six of the nine counties' enrollment increases exceeded the overall statewide enrollment percentage increase of 17.6%.

In particular, pregnancy outreach continues to show its effectiveness. Wisconsin's Medicaid for pregnant women and children who qualify at higher income levels is known as "Healthy Start". In 2001, the Healthy Start brochure for certain pregnant women and children remained one of the DHFS most requested brochures. Phone calls about the Healthy Start program to Wisconsin's Title V MCH/CSHCN Program-funded MCH hotline increased by 9% over the previous year. These outreach activities are a contributing factor to the 10.8% increase in Healthy Start enrollment in 2001. //2003//

/2004/ LPHDs remain focused on outreach. A statewide Covering Kids and Families (CKF) Coalition elected two LPHDs, City of Milwaukee and LaCrosse County, to serve as "local coalitions" in the health coverage outreach initiative. The Robert Wood Johnson Foundation funds the initiative. In addition, the Title V MCH/CSHCN Program, FHS Program Planning Analyst was elected as the CKF Coalition co-chair. Finally, several health departments continue to serve as ad hoc, unpaid volunteers in the statewide coalition. The initiative keeps the attention focused on Medicaid outreach, and address emerging problems, such as unemployed families facing health insurance loss as well as job loss.

On a less positive note, our longtime pregnancy outreach brochure, for the Healthy Start program, was discontinued. The brochure had been the department's most-requested brochure for many years. (It is now available on the Department's website.) Even so, overall Healthy Start enrollment rose in 2002 by 3.1%, from 116,492 in December 2001, to 120,128. //2004//

/2005/ *As enrollment has increased in Medicaid/BadgerCare, and overall health insurance status increased to about 97% of children status, there is comparatively less need to perform ongoing outreach. These efforts continue, but with less emphasis than in the past. To that end, the BFCH outreach consultant resigned as co-chair of the CKF Coalition in Wisconsin in order to pursue more pressing priorities such as the Blue Cross/Blue Shield Grants Initiative.* ***//2005//***

Medicaid Health Maintenance Organizations (HMOs) - The Medicaid managed care delivery system in Wisconsin encountered continuing changes, as a result of continuing market changes and consolidation in the HMO industry. Three HMOs, Compcare, Valley Health Plan, and Dean Health Plan, have decided to withdraw or reduce their enrollment. These revisions may change the need for recipients to mandatorily sign up with HMOs. However, new recipients may sign up for BadgerCare or Medicaid and be treated in a "fee-for-service" environment even if no Medicaid HMOs are available in a certain geographic area. While managed care organizations have certain benefits,

such as better performance on HealthChecks, families of children with special health care needs sometimes prefer having their children treated in a fee-for-service environment. "Non-mandatory" status allows such families to do that. Overall, 46% of the state's counties, including the state's urban areas, are considered "mandatory" counties. Most "non-mandatory" counties are concentrated in the more rural northern half of the state.

/2003/ Continued changes in Wisconsin's managed care marketplace occurred in 2001. Overall, about 280,000 Medicaid and BadgerCare recipients, or about 74% of the family Medicaid total, receive their health care though HMOs. Of particular importance to the Medicaid program was the withdrawal of Humana in the Milwaukee market. As a result, Managed Health Services HMO assumed responsibility for those Medicaid recipients who had been served by Humana. //2003//

/2004/ In 2002, no major systemic changes occurred regarding managed care for MCH populations. We will watch how the new federal regulation may cause changes in Medicaid managed care in the future. To date, we have not been invited to provide any input on this comprehensive rewrite of managed care regulations for Wisconsin. This is in contrast to a comprehensive advisory committee process when the MA managed care system expanded statewide in the late 1990s. //2004//

/2005/ *Even in a difficult state budget scenario, the state may need to increase its payments to Medicaid HMOs. The last contracts with HMOs expired at the end of 2003, though DHFS renewed the contracts for an additional four months. Some of the managed care providers have said they are unwilling to continue serving the Medicaid population without significant rate increase. When the final contract was agreed upon, effective May 2004, 13 HMOs agreed to provide services, but two more counties were designated "fee-for-service-only". //**2005**//*

Wisconsin Works (W-2) - W-2 is based on work participation and personal responsibility. The TANF program in the state is known as Wisconsin Works (W-2). Under W-2, there is not an entitlement to assistance, however there is a place for everyone who is willing to work to their ability. The program is available to eligible parents with minor children with low assets and low income. Each W-2 eligible participant meets with a Financial and Employment Planner who helps the participant develop a self-sufficiency plan and determine his/her place on the W-2 employment ladder. The ladder consists of four levels of employment and training options, in order of preference: 1) Unsubsidized Employment, 2) Trial Jobs (subsidized employment), 3) Community Service Jobs (CSJ), and 4) Wisconsin Works Transition (W-2 T).

W-2 participants are limited to 24 months in a single employment position category (Trial Jobs, CSJs, or W-2 T). The maximum lifetime limit is 60 months. Extensions may be available on a limited basis when barriers exist that prevent employment. A major part of W-2 consists of related support services and features designed to facilitate access to and sustain employment.

As a result of W-2, there has been a growing need for quality child care that is accessible, affordable and can adequately meet the complex needs of children with special health conditions. By the end of 2000, total W-2 cases in Wisconsin had dropped to 6,500 from 100,000 in 1997. A program evaluation has shown that, all W-2 participants who left the program in the first quarter of 1998, and who also filed 1999 state tax returns, reported incomes averaging $11,998. About two-thirds of this segment had incomes below the poverty level.

/2003/ In 2001, Wisconsin's W-2 program caseload increased after a significant decline in the late 1990s. According to the state DWD, the program's statewide caseload increased from 10,911 in December 2000, to 12,259 in December 2001. Wisconsin uses TANF funding for more than 40 programs such as W-2, child care, transportation, education and training, and others designed to assist low income families. TANF must be reauthorized before September 2002 for these programs to continue. //2003//

/2004/ The continuing economic downturn appears to be contributing to increased W-2 caseload numbers. In 2001, the statewide W-2 caseload increased from 10,911 in December 2000, to 12,259 in December 2001, to 14,137 in December 2002. Of that total, 78% of the cases were in Milwaukee County. The fact that caseloads have increased after the significant decline in the late 1990s is cause for concern. //2004//

/2005/ *Even as the national economy improves, the statewide total W-2 caseload numbers have continued to increase. As of April 2004, Wisconsin Works total caseloads have increased to 15,226 in Wisconsin. Of that total 79%, or 12,028 cases, are in Milwaukee County, the state's most populous county. The fact that caseloads continue to increase may be attributed to the fact that Wisconsin, with its relative dependence on the manufacturing sector, has been particularly hard-hit by manufacturing job losses. Also a potential factor is that, beginning in late 2002, the DWD began to implement its "informed choice" administrative philosophy to replace the previous "light touch" philosophy. The latter "light touch" had officially promoted the idea that "many persons do better with just a light touch; the new system should provide only as much service as an eligible person asks for or needs". However, many W-2 caseworkers interpreted this policy as meaning that they would not assist in enrolling participants in related support services, such as Medicaid and food stamps, unless the W-2 enrollee specifically asked for them. DWDs official statements had previously included the statement that "there are no entitlements," although Medicaid has always remained a legal entitlement. In summary, the more service-oriented "informed choice" approach may be responsible with enrolling more participants into W-2 and related programs such as Medicaid and food stamps.* ***//2005//***

Reproductive Health and Family Planning Services - The Title X grantee in Wisconsin is Planned Parenthood of Wisconsin, Inc. Delivery of Title X-funded family planning services is coordinated with the Title V MCH/CSHCN Program/ Wisconsin General Purpose Revenue (GPR) funded services statewide. Services are located within 68 of the 72 Wisconsin counties. Services to residents within the four counties (without services) are available in surrounding counties. Title X funds are currently used to subsidize family planning services in 13 of the 72 Wisconsin counties. Wisconsin's Title X allocation is approximately $3 million.

DPH-funded family planning services support the provision of Title X services within the 13 counties, and in the remaining eight counties historically designated as Title X. Pregnancy testing and short-term care coordination, Pap tests, sexually transmitted disease tests, chlamydia treatment medications for patients and their partners, and continuing education, training, and technical assistance (TA) for Title X providers is supported through DPHs family planning program.

/2003/ To ensure that staff working with DPH-supported family planning/reproductive health clinics are clear about policy and practice expectations, the DPH Family Planning/Reproductive Health Workgroup was formed to generate

open dialog on family planning and reproductive health issues between central regional offices. The goal is that questions and concerns can be addressed and clear, consistent messages can then be distributed. //2003//

/2004/ No significant change. //2004//

/2005/ *No significant changes.* ***//2005//***

Blue Cross/Blue Shield Public Health Foundation - Blue Cross/Blue Shield United of Wisconsin was recently granted approval to convert to a for-profit entity. As a part of that conversion, the health insurer agreed to disseminate an estimated $250 million in assets to be used for public health purposes. The state Insurance Commissioner's order allowing the conversion requires several changes to the proposed conversion plan. The proceeds from the conversion will be distributed equally to the University of Wisconsin Medical School and the Medical College of Wisconsin (MCW).

Two significant modifications are: 1) that 35% of the funds resulting from the conversion be expended only for public health and public health community based activities, and 2) that a Public and Community Health Oversight Advisory Committee (PCHOAC) be established at each of the two medical schools and that the PCHOAC have authority over the funds allocated to a public health priority. That the Commissioner has earmarked 35% of the funds to public health purposes is seen as significant. The Commissioner created an opportunity for the public health community to share responsibility with the medical schools on how these public health funds will be distributed. It also stipulates other forms of oversight to assure greater accountability.

However, ABC for Health a Madison-based legal advocacy group, filed a lawsuit and subsequent appeal challenging the Insurance Commissioner's decision. That appeal has been denied, however, and implementation of the BC/BS plan is expected to be carried out in 2001.

/2003/ According to the Office of the Commissioner of Insurance further progress on the Public Health Foundation remains contingent upon the sale of assets of Blue Cross/Blue Shield United of Wisconsin. The transfer of the corporation's stock can not occur until the corporation is sold. //2003//

/2004/ The process to distribute BCBS conversion funds gathered momentum in 2002 with the beginning meetings of the two Medical Schools' Oversight and Advisory Committees. These committees, composed of Medical School and public representatives, are charged with finalizing plans for spending the roughly $350 million in BCBS assets. Especially important is maximizing the effectiveness and efficiency of the 35% segment earmarked for projects of public health priority. Public advocates and Title V MCH/CSHCN Program representatives are monitoring the process to ensure that this money will be used to benefit public health in Wisconsin. Both schools anticipate issuing requests-for-proposals later this year or early in 2004. //2004//

/2005/ *The past 12 months was a year of significant progress for this new public health initiative, which has originated from an asset conversion of Blue Cross/Blue Shield United of Wisconsin.*

The new $600 million BC/BS fund for public health projects was launched with a competitive call for proposals in March and April of 2004. The initiative is a prime chance for public health partners to innovate, to forge partnerships, and to help transform the public health system in Wisconsin.

The two Wisconsin Medical schools' "final draft" RFPs are at: ***www.med.wisc.edu/bluecross*** *and* ***www.mcw.edu/healthierwisconsin****.*

Once the RFP is released, eligible applicants will have from two to three months to complete their applications. There are two grant categories: one-year planning grants of up to $25,000; and implementation grants of up to $150,000 per year for up to three years.

The Healthiest Wisconsin 2010 state plan's 11 health priorities, five infrastructure priorities and three overarching goals will provide applicants the framework around which to build their proposals. (website address: ***http://www.dhfs.state.wi.us/Health/StateHealthPlan****) The MCH navigational tool is also a resource.*

The initiative began in 1999, when Blue Cross/Blue Shield United of Wisconsin announced it would convert to a stock insurance corporation, dedicating the assets from the conversion to improving the public health. The conversion resulted in Wisconsin's two medical schools, the Medical College of Wisconsin and the University of Wisconsin Medical School, creating permanent endowments for the public health benefit of Wisconsin residents. Up to 35% of the funds will go to "community-academic partnerships" between eligible organizations and academic faculty.

DHFS Secretary Nelson has released the Department's nine project-area priorities. The Secretary is particularly interested in:

- *Projects that address underlying determinants of poor health outcomes, particularly: a) Promoting physical activity/appropriate nutrition, or b) Reducing tobacco use/exposure.*
- *Projects that address disparities in health outcomes, particularly: a) disparities in infant mortality and health, or b) increasing disparities in HIV/AIDS and other sexually transmitted diseases.*
- *Projects that increase access to preventive/primary oral health care.*
- *Projects that reduce: a) family violence i.e., child abuse/neglect; domestic violence; or elder abuse, b) adolescent suicides, c) lead poisoning of children, and d) falls of elderly people.*

In general, DHFS will not sponsor its own proposals; however the Secretary may grant approval for DHFS-written proposals in exceptional circumstances. DHFS staff will provide technical assistance, data resources and other help to community applicants. ***//2005//***

Tobacco Control Settlement - The Wisconsin Legislature's biennial budget, completed in 1999, created a statewide Tobacco Control Program, administered by a Tobacco Control Board. The new program is funded with a portion of the money the state received from the 1998 settlement of its lawsuit against the tobacco industry. Efforts by states to recover Medicaid costs from tobacco-related illnesses culminated when 46 states, including Wisconsin, signed a master legal settlement with five large tobacco companies. The state expects to receive about $6 billion through 2025, and about $160 million a year after that. Act 9, the Wisconsin biennial budget bill in 1999, appropriates $22.9 million for grants for these purposes:

- The Tobacco Research and Intervention Center at the University of Wisconsin-Madison.
- Smoking prevention and cessation activities at the MCW.
- The Thomas T. Melvin Youth Tobacco Prevention and Education Program.
- A youth smokeless tobacco cessation and prevention campaign in DPH.

- Various programs aimed at law enforcement, marketing, education, and treatment. Prominent target groups will include children, minorities, and pregnant women.

The Tobacco Control Board, whose meetings are open to the public, has its own website: **www.wtcb.state.wi.us**.

/2003/ As of March 2002, the Wisconsin State Assembly had voted to use all but $125 million of the tobacco settlement monies for general, non-health-related, deficit reduction. The Wisconsin Senate's version of the state budget would use the entire remaining $794 million sum in tobacco settlement monies for non-health-related purposes. As of June, the Legislature had not enacted the state budget "repair bill" however. //2003//

/2004/ In 2002, the Legislature decided to use all remaining unallocated tobacco settlement funds for general state budget deficit reduction. //2004//

/2005/ *No significant changes.* ***//2005//***